Government of the District of Columbia
Department of Health
Health Professional Licensing Administration

Board of Optometry

SUPPLEMENTAL INFORMATIONAL AND SIGNED STATEMENT OF UNDERSTANDING

Please print in ink or type your name and address where requested below:

_____
Name (Last, First, Middle Initial)

_____
Address (Street, City, State, Zip Code)

_____

1. Have you taken the National Board Examination? Yes ☐ No ☐ when:_____ score:_____
2. Have you contributed to the Optometry Literature? Yes ☐ No ☐ if so, please attach a bibliography.
3. Have you received any honors, awards or fellowships? Yes ☐ No ☐ if so, please list here_____

   _____
4. Have you received any special Optometry training, or do you have any special optometry skills. Yes No

   If so, please indicate _____

I certify that I have read and fully understand the regulations and rules governing the practice of Optometry in the District of Columbia.

_____
Signature

Return this form with your application to:

Department of Health
Health Professional Licensing Administration
Board of Optometry
825 N. Capitol Street, NE, 2nd Floor
Washington, DC 20002